STATE OF MICHIGAN

COURT OF APPEALS

ELIZABETH MORDEN, Personal Representative for the Estate of CHRISTOPHER ROBIN MORDEN,

Plaintiff-Appellant,

v

GRAND TRAVERSE COUNTY, GRAND TRAVERSE COUNTY JAIL, ELAINE LOZEN, RN, SANDI MINOR, R.N., ANNE MARIE BAASE, JIM TALBOT, TONY KARLIN, GRAND TRAVERSE SHERIFF, and NORTHERN LAKES COMMUNITY MENTAL HEALTH AUTHORITY f/k/a GREAT LAKES COMMUNITY MENTAL HEALTH,

Defendants,

and

MARILYN CONLON, MD, WELL-SPRING PSYCHIATRY, P.C., MARGARET SCHOFIELD, RN, and DAVID WILCOX, D.O.,

Defendants-Appellees.

UNPUBLISHED
January 17, 2012

No. 298458
Grand Traverse Circuit Court
LC No. 04-024311-NM

Before: SAWYER, P.J., and WHITBECK and M. J. KELLY, JJ.

PER CURIAM.

Plaintiff, Elizabeth Morden, Personal Representative for the Estate of Christopher Robin Morden, appeals of right an order granting the remaining defendants, Marilyn Conlon, M.D., Well-Spring Psychiatry, P.C., Margaret Schofield, R.N., and David Wilcox, D.O. (collectively, "defendants"), summary disposition on Morden's medical malpractice claims. The trial court held that the law of the case doctrine required dismissal because this Court had previously held, with respect to claims based on 42 USC 1983, that the opinion of Morden's psychiatric expert did not establish proximate cause. The trial court held in the alternative that defendants were entitled to summary disposition under MCR 2.116(C)(10) because the expert's opinion amounted to speculation and conjecture, and was therefore inadequate to give rise to a genuine issue of material fact on the element of proximate cause. On reconsideration, the trial court held that

Morden had not established a breach of the standard of care or proximate cause with respect to a new theory of liability. We affirm.

I. FACTS

The facts of this case were previously set forth in this Court's two prior opinions in this case:[1]

> The essential facts are largely undisputed. After being arrested on February 4, 2002, the decedent claimed that he was hearing voices and expressed thoughts of self-harm. A suicide alert was issued. The decedent was already taking prescribed medications. [On February 5, 2002,] Wilcox, the jail physician, continued the decedent's psychotropic medications of 1 mg Risperdal[1] three times daily and 40 mg Celexa[2] daily, the doses prescribed in December 2001.
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> On or around February 10, 2002, the decedent was hearing voices and wanted to hurt someone in his cell. Conlon (a consulting psychiatrist) and Wilcox visited the decedent on February 12, 2002. Conlon [believing that Morden was suffering from paranoid schizophrenia and polysubstance abuse,] recommended that Wilcox increase the decedent's Risperdal dose [and that he be rechecked in a month]. Conlon asserts that Wilcox was free to implement or reject that recommendation. The decedent's Risperdal dose was increased [by Wilcox] according to Conlon's recommendation.
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> On February 27, 2002, a sheriff's deputy found the decedent unresponsive in his cell. He was rocking back and forth in a fetal position. His speech was slow. On March 5, 2002, the decedent was again put on suicide watch after reporting that voices were telling him to stab himself with his pencil. When Conlon visited the decedent on March 12, 2002, although she noted some improvement, she recommended an increase of Risperdal. [Wilcox increased Morden's medication accordingly.]
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> Plaintiff visited the decedent on March 15, 2002, and found him acting "druggy." Plaintiff told a social worker at the jail that she was worried about her son. On March 18, 2002, the social worker reported that the decedent got dizzy and that his vision blacked out when he stood up. Wilcox [saw Morden on March 19, 2002 and] noted that . . . [he] suffered from head rushes, and that the side effects had started the last time his Risperdal dosage was increased. Wilcox took the decedent's blood pressure[3] [and noted that Morden was in no acute distress and that his vital signs were normal]. Wilcox recommended a psychiatric

[1] See *Morden v Grand Traverse Co*, 275 Mich App 325, 327-331; 738 NW2d 278 (2007) ("*Morden I*"), as quoted in *Morden v Baase*, unpublished opinion per curiam of the Court of Appeals, issued August 6, 2009 (Docket No. 285024) ("*Morden II*") (alteration by *Morden II*), pp 2-4.

consultation [regarding a possible change in medication, and ordered blood work, which was unremarkable].

On March 23, 2002, Conlon visited the decedent and noted the decedent's complaints of tingling, head rush when he stood up, and being unable to stand without holding onto a wall. Conlon stated that improvement [in Morden's psychiatric symptoms] with Risperdal was apparent, but that the drug was likely causing orthostatic hypotension,[4] so she suggested switching to a different neuroleptic, according to the following schedule:

- Seroquel (another antipsychotic medication) 100 mg at bedtime for two days, then 200 mg at bedtime for two days, then 300 mg for four days, then 400 mg at bedtime;
- Decrease Risperdal by 2 mg with each increase of Seroquel; and
- Continue Celexa dosage unchanged.

[Wilcox implemented Conlon's recommendation.] On March 26, 2002, Wilcox [saw Morden again and] noted that [he] had lost more weight, spoke in a low voice with few words, walked stiffly without head or arm movement, and was "statue-like." [Wilcox also noted that he felt that Morden might be "overmedicated," but because Morden's medication was being changed according to Conlon's suggested schedule, Wilcox did not change Morden's medication or request another consult from Conlon, instead recommending a recheck in two weeks. Wilcox then saw Morden two days later, on March 28, 2002 for an unrelated complaint regarding a possible sexually transmitted disease. Wilcox did not note any unusual behavior or symptoms at that time.]

On April 1, 2002, [while sitting at a table with other inmates, playing cards,] the decedent began clenching his fists and exhibiting seizure-like activity. He was held up by another inmate in order to prevent him from falling to the floor. The decedent was eventually lowered to the floor while the other inmates called for assistance. Cardiopulmonary resuscitation was initiated at the scene. The decedent was defibrillated within 90 seconds of the witnessed cardiac arrest but did not respond. Paramedics took the decedent to a hospital emergency department, where he arrived without any heart activity and was pronounced dead.

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[1] Risperdal is an antipsychotic medication. It is categorized as an "atypical" antipsychotic (like Clozaril, Zyprexa or Seroquel). Its method of action is that of a serotonin and dopamine receptor antagonist (SDA). *Tarascon Pocket Pharmacopoeia 2000,* p. 70.

[2] Celexa is an antidepressant medication. It is a selective serotonin reuptake inhibitor (SSRI). The maximum recommended daily dose is 40 mg. *Tarascon Pocket Pharmacopoeia 2000,* p. 68.

[3] Plaintiff posits that Wilcox apparently thought he was ruling out postural or orthostatic hypotension (a condition in which the blood pressure abnormally decreases when moving from a sitting to a standing position), which Plaintiff asserts is a sign of neuromalignant syndrome (NMS).

[4] Orthostatic hypotension, or postural hypotension, occurs when a patient stands after sitting or lying down. Falling blood pressure may cause the patient to faint. *The Signet Mosby Medical Encyclopedia* (Revised Edition, 1996), p. 407.

In *Morden v Grand Traverse Co* ("*Morden I*"), this Court held that Morden had not demonstrated the requisite deliberate indifference required for her claim against defendant Conlon based on 42 USC 1983.[2] This Court went on to hold that Morden had not established a genuine issue of material fact with respect to the proximate causation element of the § 1983 claim. Morden's proof of proximate causation was based on the conclusion of Joel M. Silberberg, M.D., Morden's psychiatric expert, that Morden's decedent died of neuroleptic malignant syndrome. This Court held that the conclusion "amount[ed] to speculation and conjecture, because it d[id] not exclude other possibilities to a reasonable degree of certainty."[3]

In *Morden v Baase* ("*Morden II*"), a panel of this Court reversed the grant of summary disposition on Morden's medical malpractice claims against defendants because Morden, the successor personal representative, timely filed the claims within two years of issuance of her letters of authority and within three years after the limitations period had run. The panel then affirmed the grant of summary disposition on the § 1983 claims against defendants Wilcox and Schofield. The panel continued:

> Further here, as we explained in our prior opinion in this case, Plaintiff's theory of causation is insufficient to establish the requisite proximate cause required by § 1983. [*Morden I*], *supra* at 335-336. Plaintiff continues to assert that Morden died from NMS, and alleges that Wilcox caused or contributed to the development of NMS, and failed to timely diagnose it, causing Morden's death. However, Wilcox and Conlon each testified that they did not believe that Morden had NMS. Additionally, both the medical examiner and Plaintiff's pathologist, Bader Cassin, opined that Morden died from cardiac arrhythmia and not from NMS.[10] And, while Plaintiff's psychiatric expert, Joel Silberberg, concluded that NMS caused plaintiff's death, this Court previously observed that "this testimony amounts to speculation and conjecture, because it does not exclude other possibilities to a reasonable degree of certainty," and that therefore, "the evidence is insufficient to raise a genuine issue of fact" as to causation. [*Morden I*], *supra* at 335.

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[2] *Morden I*, 275 Mich App at 334-335, 336-339.

[3] *Id.* at 335.

> [10] Of note, Cassin opined that Morden died of cardiac arrhythmia "probably" or "most likely" related to or precipitated by his medication. However, Cassin specifically stated that he does not believe that Morden had NMS. Cassin also noted that Morden had an enlarged AV node artery and that "numerous, if not most, of the arterials in Plaintiff's heart were thicker than normal," and he acknowledged that either of these conditions could have made Morden more prone to a sudden cardiac death. Cassin also agreed that he could not rule out that Morden suffered a sudden cardiac arrhythmia unrelated to his medications.[4]

On remand for consideration of the malpractice claims, the trial court held that the proximate cause determinations in *Morden I* and *Morden II* were the law of the case. Alternatively, the trial court found that summary disposition under MCR 2.116(C)(10) was appropriate given the failure to establish proximate cause. On reconsideration, it noted that Morden was now arguing that the decedent's medications, not neuroleptic malignant syndrome, had caused him to have a cardiac arrhythmia. With respect to this theory, it concluded that Morden had not shown that defendants failed to meet the standard of care, and that Morden could not show negligent care was a proximate cause of death. Morden now appeals.

II. LAW OF THE CASE DOCTRINE

A. STANDARD OF REVIEW

Morden argues that the trial court erred in applying the law of the case doctrine. Whether the law of the case doctrine applies is a question of law subject to this Court's de novo review.[5]

B. LEGAL STANDARDS

In *Freeman v DEC Int'l, Inc*,[6] the Court stated:

> The law of the case doctrine holds that a ruling by an appellate court on a particular issue binds that court and all lower tribunals with respect to the issue. The doctrine is, however, discretionary and merely expresses the practice of courts generally; it is not a limit on their power. Normally, the law of the case applies regardless of the correctness of the prior decision, but the doctrine is not inflexible. Michigan now recognizes at least two narrow exceptions to the doctrine. First, the decision of an appellate court is controlling at all subsequent stages of litigation unless the decision would preclude the independent review of constitutional facts. Second, the initial decision of an appellate court is controlling unless there has been an intervening change of law. For the second

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[4] *Morden II*, unpub op at 12.

[5] *Shade v Wright*, 291 Mich App 17, 21; 805 NW2d 1 (2010).

[6] *Freeman v DEC Int'l, Inc*, 212 Mich App 34, 37-38; 536 NW2d 815 (1995) (internal citations omitted).

> exception to apply, the change of law must occur after the initial decision of the appellate court. A change of law that occurs after the lower court's decision, but before the appellate court's decision, does not prevent the application of the law of the case doctrine. The remedy in that instance is a petition for rehearing or an appeal to a higher court.

"[T]he law of the case doctrine applies without regard to the correctness of the prior determination, so that a conclusion that a prior appellate decision was erroneous is not sufficient in itself to justify ignoring the law of the case doctrine."[7]

C. ANALYSIS

Morden first suggests that the same issue is not involved because the issue decided in the first two appeals was proximate causation with respect to the § 1983 action. However, for a § 1983 action for damages to be successful, the plaintiff must establish, among other things, that the violation of a federally secured right "proximately caused injury."[8] In *Mettler Walloon LLC v Melrose Twp*,[9] the Court cited *Horn* for this proposition and then went on to cite a medical malpractice case for the definition of "proximate cause":

> "'Proximate cause' is a legal term of art that incorporates both cause in fact and legal (or 'proximate') cause." *Craig v Oakwood Hosp*, 471 Mich 67, 86; 684 NW2d 296 (2004). Cause in fact requires the plaintiff to show that but for the defendant's actions, the injury would not have occurred, while legal or proximate cause normally involves examining the foreseeability of consequences. *Id*. at 86-87. . . .[10]

The injury at issue in this case for both the § 1983 claims and the medical malpractice claims was Christopher Morden's death. For these claims, the question was what proximately caused the death. This issue is no different depending on which cause of action is under consideration.

Nonetheless, Morden argues that the law of the case doctrine need not be applied because the doctrine is discretionary. However, in *Freeman*, the Court indicated that discretion will be exercised only if constitutional facts are involved or there is an intervening change in the law.[11] This case deals with state law medical malpractice claims. The facts are not constitutional. Moreover, Morden is not claiming a change in the law. Morden in essence claims that the

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[7] *Grace v Grace*, 253 Mich App 357, 363; 655 NW2d 595 (2002).

[8] *Horn v Madison Co Fiscal Court*, 22 F3d 653, 659 (CA 6, 1994).

[9] *Mettler Walloon LLC v Melrose Twp*, 281 Mich App 184, 218; 761 NW2d 293 (2008).

[10] *Id.* at 219.

[11] *Freeman*, 212 Mich App at 37-38.

decision was wrong. In Michigan, the doctrine cannot be avoided merely because a prior decision was wrong.[12]

Morden also argues that the doctrine should not be applied in this case because the proximate cause issue was not raised in the prior appeals. However, defendant Wilcox raised this issue in his brief on appeal in *Morden II*. Moreover, both Morden and defendant Wilcox addressed the proximate cause holding of *Morden I* during oral argument in *Morden II.* While the issue may not have been fully developed, it was raised.

Finally, Morden asserts that the proximate cause determination was not necessary because the dismissal of the § 1983 claims was affirmed based on the lack of a showing of deliberate indifference. However, in *Johnson v White*,[13] the Michigan Supreme Court stated, "Unlike obiter dicta, judicial dicta are not excluded from applicability of the doctrine of the law of the case." Judicial dictum results when an issue is raised, briefed, and argued by the parties.[14] In Blacks Law Dictionary (8th ed) defines "judicial dictum" as "[a]n opinion by a court on a question that is directly involved, briefed, and argued by counsel, and even passed on by the court, but that is not essential to the decision." Morden and Wilcox raised this issue at oral argument in *Morden II*. Wilcox briefed the issue, albeit in a cursory manner. Morden and Wilcox argued the point. Thus, it was judicial dicta, and the law of the case doctrine therefore applies.

III. EXPERT WITNESS TESTIMONY

Morden argues that Dr. Silberberg's opinion regarding neuroleptic malignant syndrome as the cause of death did not amount to speculation and conjecture. Because the law of the case establishes otherwise, we will not address this issue.

IV. GENUINE ISSUE REGARDING PROXIMATE CAUSE

A. STANDARD OF REVIEW

Morden asserted on remand that summary disposition was precluded because the evidence nonetheless was sufficient to show that the decedent's medications proximately caused a cardiac arrhythmia. Even if Morden could belatedly assert this theory of malpractice, her claim would fail. This Court reviews de novo a decision on a motion for summary disposition.[15]

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[12] *Grace v Grace*, 253 Mich App 357, 363; 655 NW2d 595 (2002).

[13] *Johnson v White*, 430 Mich 47, 54-55 n 2; 420 NW2d 87 (1988).

[14] *Id.*

[15] *Allison v AEW Capital Mgt, LLP*, 481 Mich 419, 424; 751 NW2d 8 (2008).

B. LEGAL STANDARDS

Summary disposition is proper under MCR 2.116(C)(10) if the documentary evidence submitted by the parties, viewed in the light most favorable to the nonmoving party, shows that there is no genuine issue regarding any material fact and that the moving party is entitled to judgment as a matter of law.[16] "[M]ere speculations are not sufficient to overcome a motion for summary disposition."[17]

In *Craig v Oakwood Hosp*, the Court stated:

> In order to establish a cause of action for medical malpractice, a plaintiff must establish four elements: (1) the appropriate standard of care governing the defendant's conduct at the time of the purported negligence, (2) that the defendant breached that standard of care, (3) that the plaintiff was injured, and (4) that the plaintiff's injuries were the proximate result of the defendant's breach of the applicable standard of care. . . .[18]

C. ANALYSIS

Dr. Silberberg in essence believed that the medications caused neuroleptic malignant syndrome and that in turn caused a cardiac arrest. Dr. Cassin believed the medications caused a disruption in the normal cardiac rhythm. However, there was no testimony that recommending, prescribing, or administering the medications was a breach of the standard of care. There has also been no expert testimony that too much medication caused the arrhythmia. Neither Dr. Silberberg nor Dr. Cassin took issue with the fact that the medications were appropriately prescribed given the decedent's condition. Morden's theory was that testing and monitoring should have been done to confirm neuroleptic malignant syndrome and if neuroleptic malignant syndrome were found, then the medications should have been stopped.

Even if, consistent with Cassin's testimony, the medications caused a disruption in the heart rhythm, there was no testimony that the medications should have been abruptly stopped at the onset of symptoms typical of the medications. In fact, Dr. Silberberg said it would be appropriate to lessen the dosage, as was done here. Thus, even if the medications caused a cardiac arrhythmia, there simply is no basis for finding a breach of the standard of care relative to prescribing or administering the medications.

We affirm.

/s/ David H. Sawyer
/s/ William C. Whitbeck
/s/ Michael J. Kelly

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[16] *Veenstra v Washtenaw Country Club*, 466 Mich 155, 164; 645 NW2d 643 (2002).

[17] *LaMothe v Auto Club Ins Ass'n*, 214 Mich App 577, 586; 543 NW2d 42 (1995).

[18] *Craig v Oakwood Hosp*, 471 Mich at 86-88.